to participants, beneficiaries, or enrollees under a group health plan or group or individual health insurance coverage, as applicable[1] offered by a health insurance issuer and any enforcement actions taken against providers or facilities as a result of such violations, including the disposition of any such enforcement actions.

(b) Secretarial enforcement authority

(1) In general

If a provider or facility is found by the Secretary to be in violation of a requirement to which subsection (a)(1) applies, the Secretary may apply a civil monetary penalty with respect to such provider or facility (including, as applicable, a provider of air ambulance services) in an amount not to exceed $10,000 per violation. The provisions of subsections (c) (with the exception of the first sentence of paragraph (1) of such subsection), (d), (e), (g), (h), (k), and (*l*) of section 1320a—7a of this title shall apply to a civil monetary penalty or assessment under this subsection in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a) of such section.

(2) Limitation

The provisions of paragraph (1) shall apply to enforcement of a provision (or provisions) specified in subsection (a)(1) only as provided under subsection (a)(2).

(3) Complaint process

The Secretary shall, through rulemaking, establish a process to receive consumer complaints of violations of such provisions and provide a response to such complaints within 60 days of receipt of such complaints.

(4) Exception

The Secretary shall waive the penalties described under paragraph (1) with respect to a facility or provider (including a provider of air ambulance services) who does not knowingly violate, and should not have reasonably known it violated, section 300gg–131 or 300gg–132 of this title (or, in the case of a provider of air ambulance services, section 300gg–135 of this title) with respect to a participant, beneficiary, or enrollee, if such facility or provider, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

(5) Hardship exemption

The Secretary may establish a hardship exemption to the penalties under this subsection.

(c) Continued applicability of State law

The sections specified in subsection (a)(1)[2] shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of such a section.

(July 1, 1944, ch. 373, title XXVII, § 2799B–4, as added Pub. L. 116–260, div. BB, title I, § 104(a), Dec. 27, 2020, 134 Stat. 2829.)

§ 300gg–135. Air ambulance services

In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished in a plan year beginning on or after January 1, 2022, air ambulance services (for which benefits are available under such plan or coverage) from a nonparticipating provider (as defined in section 300gg–111(a)(3)(G) of this title) with respect to such plan or coverage, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such service furnished by such provider that is more than the cost-sharing amount for such service (as determined in accordance with paragraphs (1) and (2) of section 300gg–112(a) of this title, section 1185f(a) of title 29, or section 9817(a) of title 26, as applicable).

(July 1, 1944, ch. 373, title XXVII, § 2799B–5, as added Pub. L. 116–260, div. BB, title I, § 105(b), Dec. 27, 2020, 134 Stat. 2851.)

§ 300gg–136. Provision of information upon request and for scheduled appointments

Each health care provider and health care facility shall, beginning January 1, 2022, in the case of an individual who schedules an item or service to be furnished to such individual by such provider or facility at least 3 business days before the date such item or service is to be so furnished, not later than 1 business day after the date of such scheduling (or, in the case of such an item or service scheduled at least 10 business days before the date such item or service is to be so furnished (or if requested by the individual), not later than 3 business days after the date of such scheduling or such request)—

(1) inquire if such individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a Federal health care program (and if is so enrolled in such plan or coverage, seeking to have a claim for such item or service submitted to such plan or coverage); and

(2) provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item or service, to—

(A) in the case the individual is enrolled in such a plan or such coverage (and is seeking to have a claim for such item or service submitted to such plan or coverage), such plan or issuer of such coverage; and

[1] So in original. Probably should be followed by a comma.

[2] So in original. Subsec. (a)(1) specifies ''this part'', but does not specify individual sections.

(B) in the case the individual is not described in subparagraph (A) and not enrolled in a Federal health care program, the individual.

(July 1, 1944, ch. 373, title XXVII, § 2799B–6, as added Pub. L. 116–260, div. BB, title I, § 112, Dec. 27, 2020, 134 Stat. 2866.)

§ 300gg–137. Patient-provider dispute resolution

(a) In general

Not later than January 1, 2022, the Secretary shall establish a process (in this subsection referred to as the ''patient-provider dispute resolution process'') under which an uninsured individual, with respect to an item or service, who received, pursuant to section 300gg–136 of this title, from a health care provider or health care facility a good-faith estimate of the expected charges for furnishing such item or service to such individual and who after being furnished such item or service by such provider or facility is billed by such provider or facility for such item or service for charges that are substantially in excess of such estimate, may seek a determination from a selected dispute resolution entity for the charges to be paid by such individual (in lieu of such amount so billed) to such provider or facility for such item or service. For purposes of this subsection, the term ''uninsured individual'' means, with respect to an item or service, an individual who does not have benefits for such item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program (as defined in section 1320a–7b(f) of this title), or a health benefits plan under chapter 89 of title 5 (or an individual who has benefits for such item or service under a group health plan or individual or group health insurance coverage offered by a health insurance issuer, but who does not seek to have a claim for such item or service submitted to such plan or coverage).

(b) Selection of entities

Under the patient-provider dispute resolution process, the Secretary shall, with respect to a determination sought by an individual under subsection (a), with respect to charges to be paid by such individual to a health care provider or health care facility described in such paragraph for an item or service furnished to such individual by such provider or facility, provide for—

(1) a method to select to make such determination an entity certified under subsection (d) that—

(A) is not a party to such determination or an employee or agent of such party;

(B) does not have a material familial, financial, or professional relationship with such a party; and

(C) does not otherwise have a conflict of interest with such a party (as determined by the Secretary); and

(2) the provision of a notification of such selection to the individual and the provider or facility (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the ''selected dispute resolution entity'' with respect to such determination.

(c) Administrative fee

The Secretary shall establish a fee to participate in the patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to such process.

(d) Certification

The Secretary shall establish or recognize a process to certify entities under this subparagraph.[1] Such process shall ensure that an entity so certified satisfies at least the criteria specified in section 300gg–111(c) of this title.

(July 1, 1944, ch. 373, title XXVII, § 2799B–7, as added Pub. L. 116–260, div. BB, title I, § 112, Dec. 27, 2020, 134 Stat. 2867.)

§ 300gg–138. Continuity of care

A health care provider or health care facility shall, in the case of an individual furnished items and services by such provider or facility for which coverage is provided under a group health plan or group or individual health insurance coverage pursuant to section 300gg–113 of this title, section 9818 of title 26, or section 1185g of title 29—

(1) accept payment from such plan or such issuer (as applicable) (and cost-sharing from such individual, if applicable, in accordance with subsection (a)(2)(C) of such section 300gg–113 of this title, 9818 of title 26, or 1185g of title 29) for such items and services as payment in full for such items and services; and

(2) continue to adhere to all policies, procedures, and quality standards imposed by such plan or issuer with respect to such individual and such items and services in the same manner as if such termination had not occurred.

(July 1, 1944, ch. 373, title XXVII, § 2799B–8, as added Pub. L. 116–260, div. BB, title I, § 113(d), Dec. 27, 2020, 134 Stat. 2873.)

§ 300gg–139. Provider requirements to protect patients and improve the accuracy of provider directory information

(a) Provider business processes

Beginning not later than January 1, 2022, each health care provider and each health care facility shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer offering group or individual health insurance coverage to support compliance by such plans or issuers with section 300gg–115(a)(1) of this title, section 1185i(a)(1) of title 29, or section 9820(a)(1) of title 26, as applicable. Such providers shall submit provider directory information to a plan or issuers, at a minimum—

(1) when the provider or facility begins a network agreement with a plan or with an issuer with respect to certain coverage;

(2) when the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage;

[1] So in original.